

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial permit. Then please remove this page. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removed.

IMPORTANT: If Item 21 is marked as Item 18, please mark Item 21 as Item 18.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										07/22			
										REG. NO.			
DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
William James Brain						March 7, 1984			9:58P M				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1920</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Charles</b>			MD.			
10. CITY OR TOWN OF DEATH <b>LaPlata</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Physicians Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supply Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Waldorf</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>311 Lake Drive 20601</b>					
14. FATHER'S NAME FIRST <b>Simeon</b>			MIDDLE LAST <b>Brain</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Harper</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 175-01-8989</b>			17. INFORMANT <b>Mabel T. Brain same as 13</b>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery Disease</b> (c) <b>Diabetes mellitus</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>March 2 1984</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>7:45 AM</b> 19 <b>84</b> to <b>March 8, 19 84</b> , that (I) (we) last saw the deceased alive on <b>March 2 19 84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Michael A. Leatherwood</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>3/8/84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael A. Leatherwood M.D.</b>			22e. ADDRESS <b>Waldorf Medical Park, Waldorf, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL <b>Bufail</b>			23b. DATE <b>3-10-84</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Trinity Mem. Gardens</b>			23d. LOCATION CITY OR TOWN <b>Waldorf, Charles, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Huntt Funeral Home, Waldorf, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>MAR 12 1984</b> 25b. REGISTRAR'S SIGNATURE <i>Jude S. Sander</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 27123

1. DECEASED NAME (TYPE OR PRINT)			FIRST Hattie	MIDDLE Marguerite	LAST Burch	2a. DATE OF DEATH MONTH March	DAY 23, 1984	YEAR	2b. HOUR 1:05 P.M.
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH MONTH 12-3-1895	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles	MD.					
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box 195, Mattawoman Beach	20601 town Rd. 20601				
14. FATHER'S NAME FIRST Henry	MIDDLE Arthur	LAST Roberts	15. MOTHER'S MAIDEN NAME FIRST Mary	MIDDLE Frances	ADDRESS Berry	20601			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 4850	17. INFORMANT (Son) Joseph L. Burch, Same as Line 13	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Bronchopneumonia - bilateral DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. atherosclerotic heart disease, chronic brain syndrome									
19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	21d. INJURY OCCURRED WHITE <input type="checkbox"/> INDUSTRIAL <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>						
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —	21f. LOCATION STREET —	CITY OR TOWN —	21g. COUNTY —	21h. STATE —					
22a. I certify that (I) (this hospital) attended the deceased from 3/14/84, 19, to 3/23/84, 19, that (I) (we) last saw the deceased alive on 3/23/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sanjeee Mishra Dr. Sanjeeb K. Mishra, M.D.			DEGREE for G.S. Rathi	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-23-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Sanjeeb K. Mishra, M.D.			22e. ADDRESS Charles Professional Building Waldorf, Maryland 20601						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-26-1984	23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. Gdns.	23d. LOCATION CITY OR TOWN Waldorf, Charles, Md.	23e. COUNTY —	23f. STATE —				
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland	ADDRESS	25a. DATE REC'D. BY REGISTRAR MAR 27 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT IN FULL. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>C</u> Charles MIDDLE <u>F</u> Frederick LAST <u>Coleman</u>			2a. DATE KNOWN OF DEATH ESTIMATED			2b. MONTH <u>March</u> DAY <u>16</u> YEAR <u>1984</u>	2b. HOUR <u>10:21</u> AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH <u>July</u> DAY <u>8</u> YEAR <u>1930</u>		6. AGE (IN YEARS (LAST BIRTHDAY) YRS.)		7. IF UNDER 1 YR. MONTHS <u>53</u> DAYS <u>0</u>		8. IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Charles</u>		13c. CITY OR TOWN <u>Indian Head</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>43 Greenwood Place, 20640</u>			
14. FATHER'S NAME FIRST <u>Harry</u>		MIDDLE <u>D.</u>		LAST <u>Coleman</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Emily</u>		MIDDLE <u>Marie</u>			LAST <u>Beamer</u>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>Korean</u>		16c. ADDRESS		17. INFORMANT (Wife) <u>Jane G. Coleman, Same as Line 13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF  (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. <u>19</u> MONTH <u>DAY</u> <u>YEAR</u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>C. Philip Carter</u> TITLE (SPECIFY) M.D. <u>Sub Deputy</u> MEDICAL EXAMINER											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Burial</u> <u>3-19-84</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Charles Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Indian Head, Chas., Md.</u>		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <u>Huntt Funeral Home, Waldorf, Md.</u>		25a. DATE RECD. BY REGISTRAR <u>MAR 19 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Johanna Davidson Pendell</u>							
20. ADDRESS											



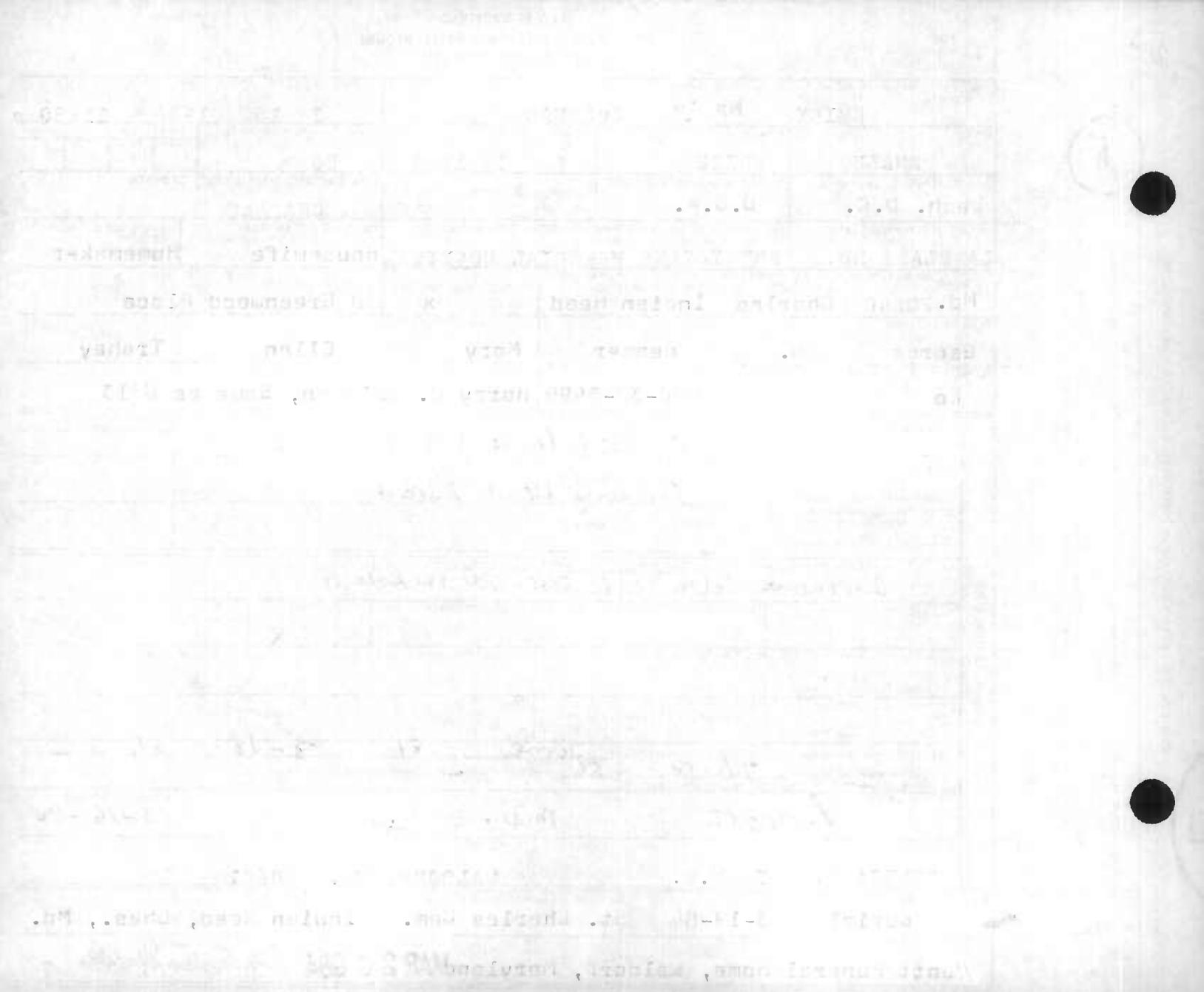
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07125					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
EMILY Marie COLEMAN						3 16 1984						11:30 Ma			
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
FEMALE			WHITE		6 29 1903						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Wash. D.C.			U.S.A.								CHARLES				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
LA PLATA MD.			PHYSICIANS MEMORIAL HOSPITAL										Housewife		
13a. STATE Md. 20640			13b. COUNTY Charles		13c. CITY OR TOWN Indian Head			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 30 Greenwood Place				
14. FATHER'S NAME George			MIDDLE W.	LAST Beamer			15. MOTHER'S MAIDEN NAME Mary			MIDDLE Ellen	LAST Trahey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 220-32-5499			17. INFORMANT			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro pulmonary arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>coronary heart disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma colon with extensive metastasis</i> DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a 21a. DATE OF OPERATION															
21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19															
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19 81</i> to <i>3-16-1984</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>July 18 1984</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.															
22b. SIGNATURE <i>Giriya S. Rath M.D.</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GIRIJA S. RATH M.D.			22e. ADDRESS WALDORF, MD. 20601			22f. DATE SIGNED 3-16-84									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-19-84			23c. NAME OF CEMETERY OR CREMATORIAL St. Charles Cem.			23d. LOCATION CITY OR TOWN Indian Head, Chas., MD.			23e. COUNTY			
24 FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland			25a. DATE REC'D. BY REGISTRAR MAR 21 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pender									
DHMH - 16 50M 4/B2 (VRA 15, 4)															



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WHICH IS THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, OR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR ESTI-DEATH MATED <input type="checkbox"/> 3 12 1984										
1. DECEASED NAME (TYPE OR PRINT) TAMARA (Tammy)			MIDDLE Lynn			LAST Crosser			2b. HOUR 2d. HOUR				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 15, 57		6. AGE (IN YEARS LAST BIRTHDAY) 26 yrs.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. CITIZEN OF WHAT COUNTRY? U. S. of A.		9c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9d. DATE PRONOUNCED DEAD 3 12 1984		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY At home							
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Bel Alton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS P.O. Box 1414, La Plata 20646					
14. FATHER'S NAME FIRST James		MIDDLE Russell		15. MOTHER'S MAIDEN NAME Earlene		16. ADDRESS Same as # 13 -Husband		17. INFORMANT Thomas M. Crosser					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-72-3883		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) <b>Multiple injuries</b> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF		19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 11:13 A.M. 3 12 1984		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 301 nr. Central Ave., Waldorf, Charles, Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		22c. TITLE (SPECIFY) M. Deputy Chief MEDICAL EXAMINER		22d. DATE SIGNED 3/13/84							
23a. EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		23b. ADDRESS 111 Penn St. Balto., MD.		23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23d. DATE March 16, 1984		23e. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23f. LOCATION CITY OR TOWN COUNTY STATE Clinton, Prince Geo., Md.			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.		25a. DATE REC'D. BY REGISTRAR MAR 19 1984		25b. REGISTRAR'S SIGNATURE Julie Davidson									
25c. DHMH - 17 (VR A15 ME (5)) 20M 4/22													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 07721			
1 - STATE REGISTRAR			1. DECEASED NAME [TYPE OR PRINT]			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Vincent Charles Emrich						March 7, 1984			8:55 A M			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR			
Male			Cau.			April 17, 1943			40			MONTHS		# UNDER 24 HRS	
7b. BIRTHPLACE [STATE OR FOREIGN COUNTRY]			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS		DAYS	
Wash. D.C.			U.S.A.						Charles			HRS.		MIN.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION [IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS]			12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE]			12b. KIND OF BUSINESS OR INDUSTRY						
Hughesville			Rt.#1 Box 238			Driver			Fleck Co.						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Maryland			Charles			Hughesville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt.#1 Box 238 20637			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Edwin F. Emrich, Sr.			Margaret Frazier												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? [YES, NO OR UNKNOWN]			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
NO			220-40-4776			Edwin F. Emrich, Jr. same as 11									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tumor of Carcinoma</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>															
<p>1460 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b) _____ DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____ DUE TO, OR AS A CONSEQUENCE OF</p>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>NONE</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <i>7-8</i> , 19 <i>83</i> , to <i>3-07</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Feb. 24</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Dr. Ronald Landman</i>			22c. DEGREE <i>M.D.</i>			22d. DATE SIGNED <i>3-7-84</i>									
22e. ADDRESS Dr. Ronald Landman, M.D.															
23a. BURIAL, CREMATION, REMOVAL [SPECIFY] <i>Cremation</i>			23b. DATE <i>3-10-84</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Huntt Crematory</i>			23d. LOCATION CITY OR TOWN <i>Waldorf, Charles, Maryland</i>						
24. FUNERAL DIRECTOR NAME <i>Huntt Funeral Home, Waldorf, Maryland</i>			25a. DATE REGD. BY REGISTRAR <i>MAR 8 1984</i>			25b. REGISTRAR'S SIGNATURE <i>Ronald Landman</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked DEATH, Item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												07128								
1. FOR STATE REGISTRAR												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>Manuel</u>			MIDDLE <u>Manuel</u>			LAST <u>Gaines</u>			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS		8. DAYS	9. HOURS					
MALE			B			MONTH 10 DAY 1 YEAR 05			78			YRS.		9. BALTIMORE CITY OR COUNTY OF DEATH		CHARLES				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Md			U.S.A.									La Plata		Ches. Co. Nursing Home			farmer		MD.	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		14. FATHER'S NAME						
Md.			Charles			Nanney						Box 96		AMOS			LAST GAINES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			214-28-4921			EMMA Wilson			Irreversible respiratory collapse			Box 96			10m					
									Due to, or as a consequence of (b) End stage renal disease			GRAYTON, MD. 20662			1 Year					
									Due to, or as a consequence of (c) Small artery disease of diabetes.						3510m					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>Hypertension secondary to the small artery disease</i>																				
18c. MEDICAL CERTIFICATION			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>April 1st</u> 19 <u>77</u> to <u>March 30</u> 19 <u>84</u> , that (1) (we) last saw the deceased alive on <u>March 30</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			22b. SIGNATURE <i>Arthur O. Woodey MD</i>			22c. DEGREE DEGREE			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR O. WOODEY M.D.			22e. ADDRESS 6040 LA PLATA, MD 20646			22f. DATE SIGNED 30 Mar 84					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-4-84			23c. NAME OF CEMETERY OR CREMATORIAL OAK GROVE			23d. LOCATION CITY OR TOWN CHARLES, MD			24. FUNERAL DIRECTOR NAME THORNTON FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR APR 4 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		
BP																				
DHMH - 16 50M 4/B2 (VRA 15, 4)																				

— Oak Glass

4-4-24 OAK GROVE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7729

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE ELIZABETH	LAST GRABIS	2a. DATE KNOWN MONTH DAY YEAR DEATH ESTI- MATED				2b. HOUR 130 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 18 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		7c. DATE PRONOUNCED DEAD 3 26 1984				2d. HOUR 3 26 1984			
10. CITY OR TOWN OF DEATH Bryans Road		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 2, Box 183				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Bryans Road		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2, Box 183, 20616					
14. FATHER'S NAME Otto		MIDDLE O.		LAST Koontz		15. MOTHER'S MAIDEN NAME Myrtle		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-18-9190	
17. INFORMANT Edward J. Grabis, Sr., Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 1990 IMMEDIATE CAUSE (a) Disseminated carcinomatosis Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Huntt Funeral Home</u>		22b. TITLE (SPECIFY) M.D. Charles G. Huntt, Jr., MEDICAL EXAMINER				DATE SIGNED 26 March 84							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-29-1984		23c. NAME OF CEMETERY OR CREMATORIAL St. Charles Cemetery		23d. LOCATION CITY OR TOWN Glymont CHARLES, MD.		25a. DATE REC'D. BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Md.		25c. ADDRESS				25d. REGISTRAR'S SIGNATURE							

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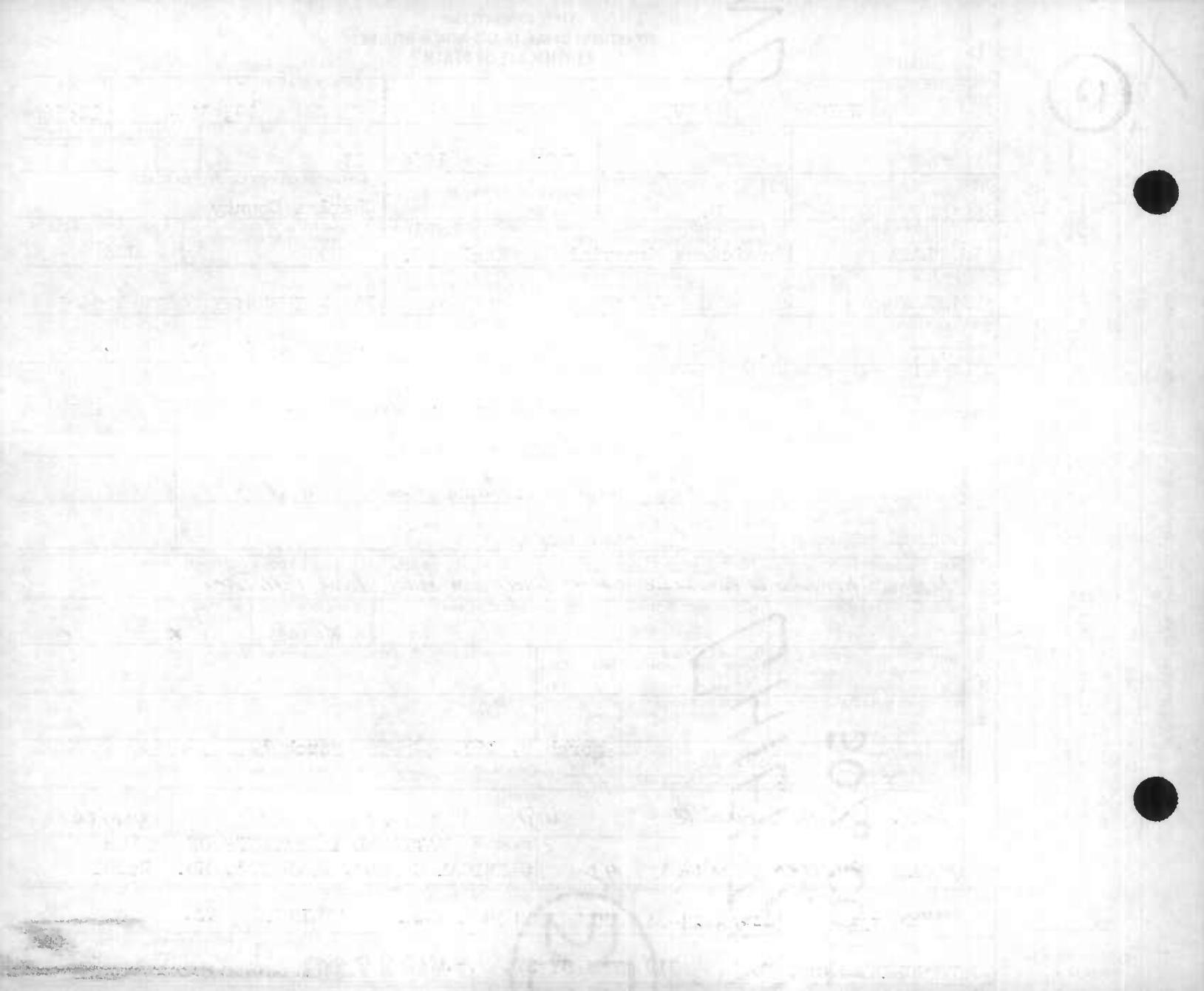
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked Q Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										07 / 30							
										REG. NO.							
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
		ERIC			MELVIN		HICKERSON				MARCH		19	1984	12:56pm		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.						
MALE		NEGRO			MONTH JULY DAY 2 YEAR 1966			17									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.						
DULMUTH MINN.		U. S.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			LaPlata Physicians Memorial Hospital Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
LA PLATA								NONE			NONE						
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN WALDORF		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS 749 UNIVERSITY DRIVE 20601								
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
14. FATHER'S NAME FIRST ERNEST		MIDDLE A.			LAST HICKERSON		15. MOTHER'S MAIDEN NAME FIRST ANNETT			MIDDLE PERRY			LAST HICKERSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS									
NO		218-84-3551			Annett P. Hickerson (mother) same as patient												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4960			Cardiopulmonary arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
					DUE TO, OR AS A CONSEQUENCE OF (b) Severe obstructive lung disease and												
					DUE TO, OR AS A CONSEQUENCE OF (c) Car pulmonaryae												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Malnutrition due to pancreatic insufficiency and chronic lung infection																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital attended the deceased from March 9, 1971 to March 19, 1984, that (I/we) last saw the deceased alive on Feb. 22, 1984, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Milica Sisonska Chernick					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/20/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Milica Sisonska Chernick					22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD. 20205												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE MARCH 23-84			23c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT. CEM.			23d. LOCATION CITY OR TOWN ARLINGTON, VA.			COUNTY	STATE					
24. FUNERAL DIRECTOR NAME MONTGOMERY BROS. F. H.					ADDRESS 719 KENNEDY ST, N.W.			25a. DATE REC'D. BY REGISTRAR MAR 27 1984			25b. REGISTRAR'S SIGNATURE Suzi Daunder-Randall						



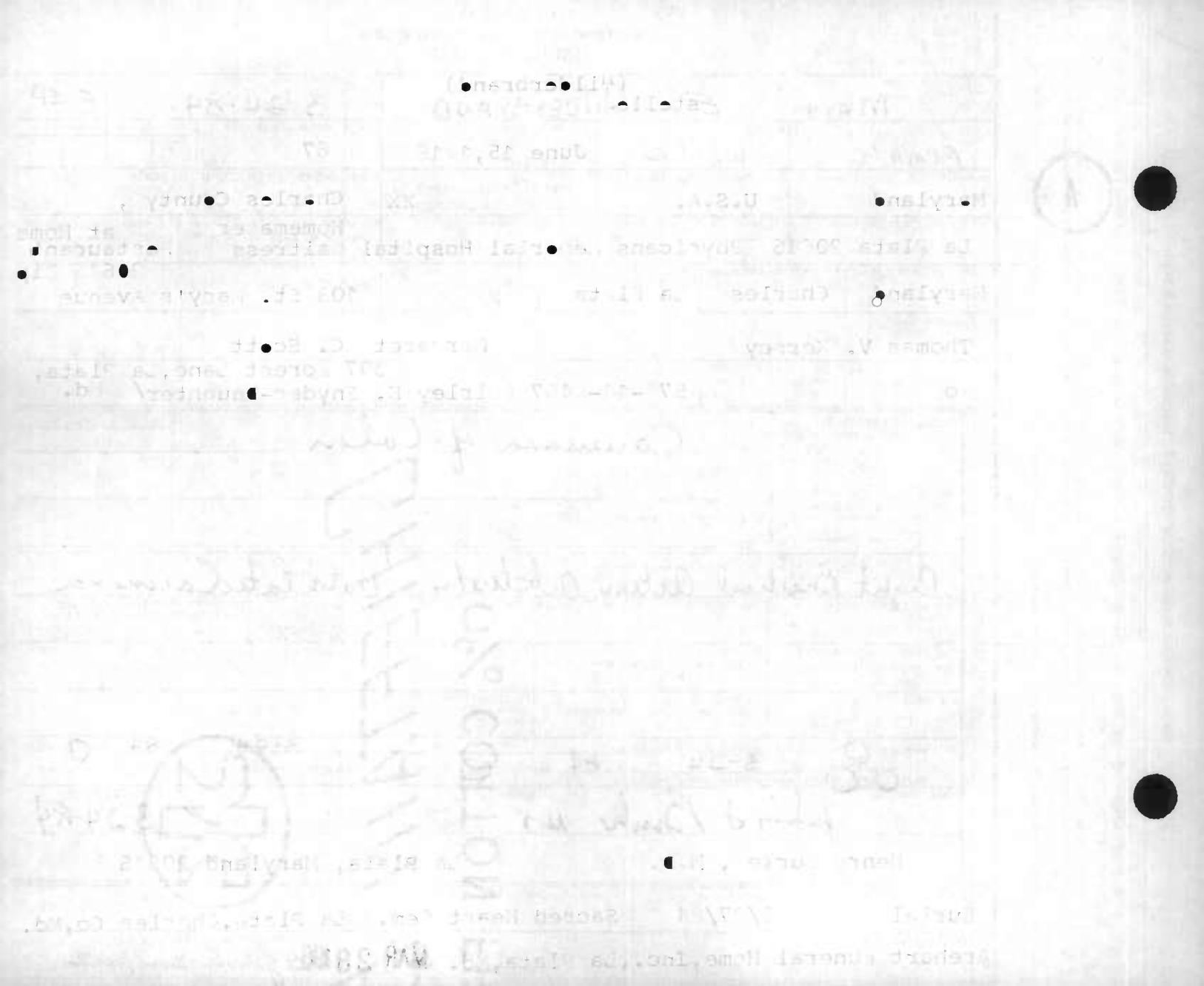
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 states any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7731									
1. FOR STATE REGISTRAR			REG. NO.																		
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mary	MIDDLE Estelle	(Hildebrand)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 505P M											
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH June 15, 1916 DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 67			IF UNDER 1 YEAR MONTHS DAYS											
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.			10. CITY OR TOWN OF DEATH La Plata 20646			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL RESIDENCE & (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress			12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN La Plata			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 103 St. Mary's Avenue			20646 Zip								
14. FATHER'S NAME FIRST Thomas V. Kersey						15. MOTHER'S MAIDEN NAME FIRST Margaret C. Scott															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No		17. INFORMANT 307 Forest Lane, La Plata, Shirley H. Snyder-Daughter/ Md.																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Caecumna of Colon</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF																					
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Right Burchal Atery Obstruct, Metastatic Caecumna</u>																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>3-24</u> 19 <u>84</u> , to <u>3-24</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-24</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																					
22b. SIGNATURE <u>Henry Burke</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>3-24-84</u>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Burke, M.D.			22e. ADDRESS La Plata, Maryland 20646																		
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 3/27/84			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sacred Heart Cem.			23d. LOCATION CITY OR TOWN La Plata, Charles Co., Md.												
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc., La Plata, Md.						25a. DATE REC'D. BY REGISTRAR MAR 28 1984			25b. REGISTRAR'S SIGNATURE Julia Davison Pendell												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN A COPY FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 101 / 32

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR		
			DAVID	LAWRENCE	HINELY	3-8-84			19	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Male	Cau.	July 8, 37	46 yrs.			3-8-84			19	M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Washington, D.C.		USA				Charles County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
LaPlata		Physician's Memorial Hospital			Cartographer			U.S. Gov't				
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS (20601) Box 56, Forest Cross Road					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Vance		Adams		Hinely	Catherine Gertrude Hayes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS						
Yes		1961-1962		213-40-9750		Enid J. Hinely, Same as line 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication												
9520 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: } DUE TO, OR AS A CONSEQUENCE OF												
(b) } DUE TO, OR AS A CONSEQUENCE OF												
(c) }												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 2:40PM 3-8-84			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject inhaled exhaust fumes from truck							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) garage			21f. LOCATION Forest Cross Rd. Box 57 Waldorf, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			DATE SIGNED 3-9-84							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial		3-13-1984			Md. Veteran's Cemetery, Cheltenham, Chas.			Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Huntt Funeral Home, Waldorf, Md.					MAR 12 1984			John J. Huntt				

Q) LOW TIDE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07733			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
ERNEST Christian JANSEN						3 25 1984			5:03 PM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 11 DAY 15 YEAR 1916			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES		MD.				
10. CITY OR TOWN OF DEATH LA PLATA, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Head Stockman			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.						
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Newburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1 Box 20 ZIP 20664				
14. FATHER'S NAME FIRST Christian		MIDDLE Jansen		15. MOTHER'S MAIDEN NAME FIRST Laura Alice			MIDDLE Bollman		LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-0325		17. INFORMANT Florence D. Jansen same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1930 Advanced Metastatic Thyroid Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) this hospital attended the deceased from 3/24 1984 to 3/25 1984, that (I) (we) last saw the deceased alive on 3/25 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John W. Wataan		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 3/25/84							
22f. ADDRESS La Plata, Md. 20664													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-28-84		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem. Garden			23d. LOCATION CITY OR TOWN Waldorf		23e. COUNTY Charles		23f. STATE Md.		
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.		ADDRESS La Plata, Md.		25a. DATE REC'D. BY REGISTRAR APR 4 1984		25b. REGISTRAR'S SIGNATURE John Davidson Pendell							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section should be completed at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												07/34										
												REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR							
Alonzo			T.		Johnson					March 22, 1984					11:52 A							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 24 HRS.		8. IF UNDER 24 HRS.											
Male		Black		Jan. 22, 1897			87		MONTHS		DAYS		HOURS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH															
Washington, D.C.		UNITED STATES					Charles															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
La Plata		Physicians Memorial Hospital		Pipe Fitter			Government															
13a. STATE Maryland												13b. COUNTY Charles		13c. CITY OR TOWN LaPlata			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2 Box 2102		20646	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
John				Alice			No		220-38-2845-A		Geraldine Woodland		LaPlata, Maryland 20646									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												HYPOVOLEMIA DUE TO GASTRO-INTESTINAL BLEEDING APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days										
2639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)												STRESS ULCER 1-2 WEEKS										
DUE TO, OR AS A CONSEQUENCE OF (c)												MALNUTRITION-INANITION 2 WEEKS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTHRITIS, URINARY TRACT INFECTION, COLOSTOMY.																						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																
YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE												
22a. I certify that (I) (this hospital) attended the deceased from 3-16, 1984, to 3-22, 1984, that (I) (we) last saw the deceased alive on 3-22, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Aurelio C. de la Paz, M.D.		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3-22-84														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																				
Aurelio Delapaz, M.D.		La Plata, Md. 20646																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE March 27, '84		23c. NAME OF CEMETERY OR CREMATORIAL Macedonia Bapt.		23d. LOCATION CITY OR TOWN Bryans Road		COUNTY Charles		STATE Md.												
24. FUNERAL DIRECTOR NAME Thornton Funeral Home		ADDRESS Pomonkey, Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1984		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall																
BP																						

888 AM

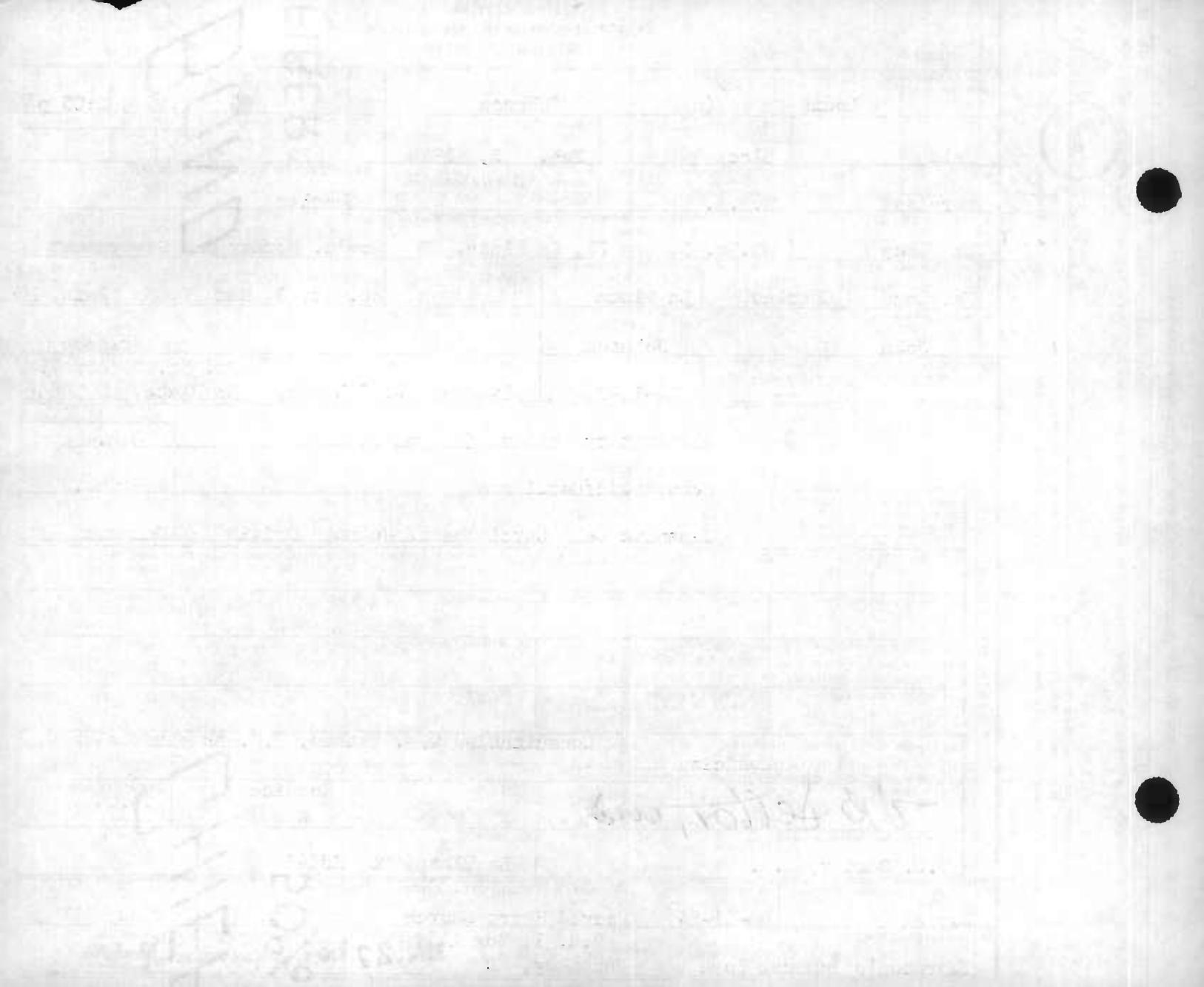
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please notify the retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6 3 7735				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH 03 17, 1984							2b. HOUR 2:05 p.m.				
1. DECEASED NAME (TYPE OR PRINT) Louis (n) Johnson			5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 70 yrs			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
3. SEX Male			4. RACE Black			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.		
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Rt. 3, Box 77, La Plata, MD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gov't. Worker HEW			12b. KIND OF BUSINESS OR INDUSTRY Government					
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN La Plata			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE St. Rt. 3, Box 77, La Plata, MD 20646		
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Johnson Susie			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -- 214-12-9291A			17. INFORMANT ADDRESS Elizabeth L. Johnson, St. Rt. 3, Box 77 La Plata, MD 20646		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure (Cheyne-Stokes)</u>						DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic/Carcinoma</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 h.		
1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any						DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous Cell Carcinoma of Unknown Origin</u>						4-6 wks.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from <u>Consultation w/G. Wathen, M.D. as personal physician</u> 19 <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>V.B. Dettor, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL STAFF DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 03/17/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.B. Dettor, M.D.			22e. ADDRESS La Plata, MD 20646											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 03-21-84			23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Church			23d. LOCATION CITY OR TOWN La Plata			COUNTY Charles		STATE MD
24. FUNERAL DIRECTOR NAME Thornton's Funeral Home			ADDRESS R.R. 1, Box 111 Pomonkey, MD			25a. DATE REC'D. BY REGISTRAR MAR 22 1984			25b. REGISTRAR'S SIGNATURE Julie Davidson - <u>Renfrew</u>					

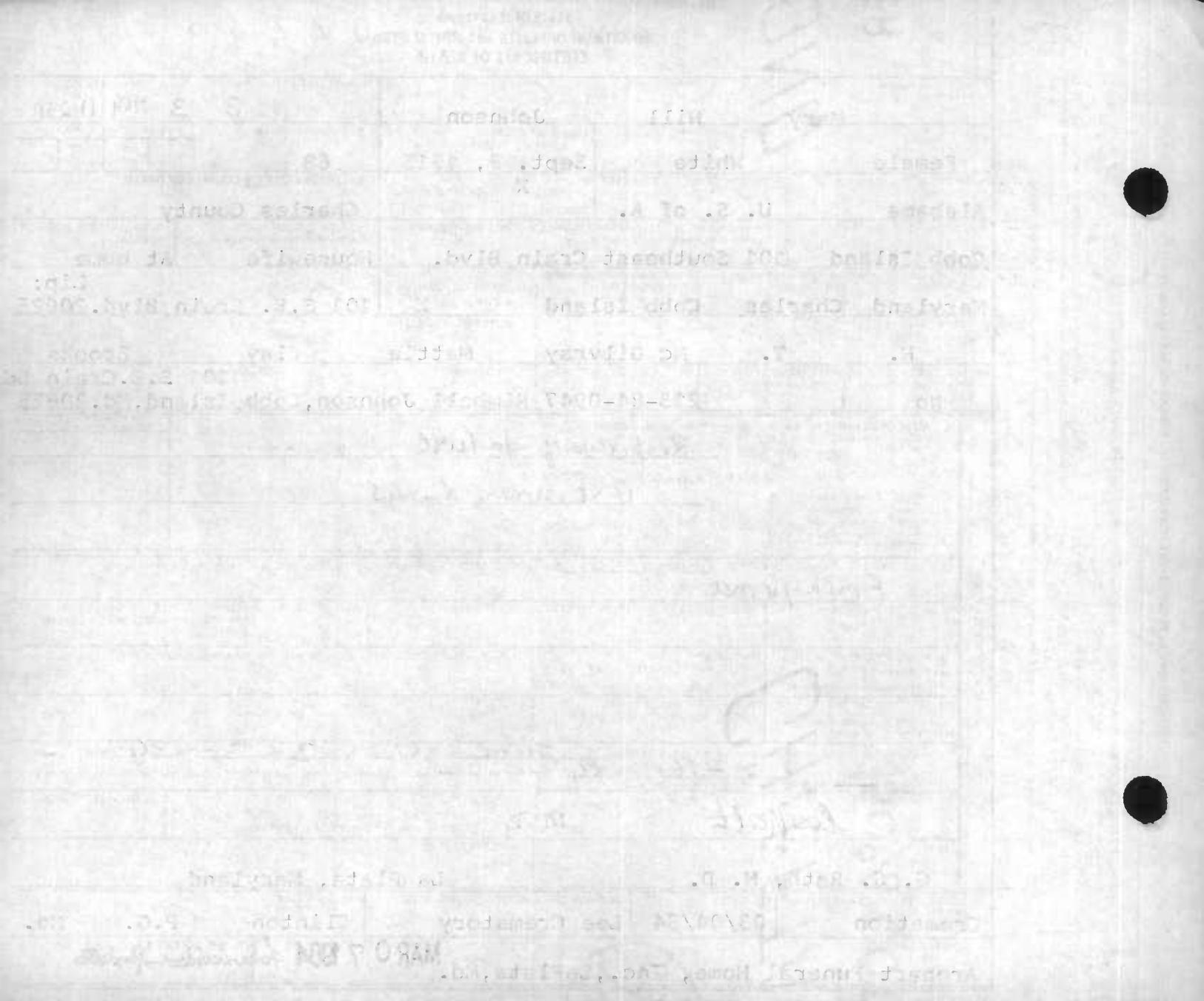


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be affixed here for use as the burial permit. Then please return carbon papers. Page 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows one injury or other traumatic event, the medical certificate must be completed on page 4.

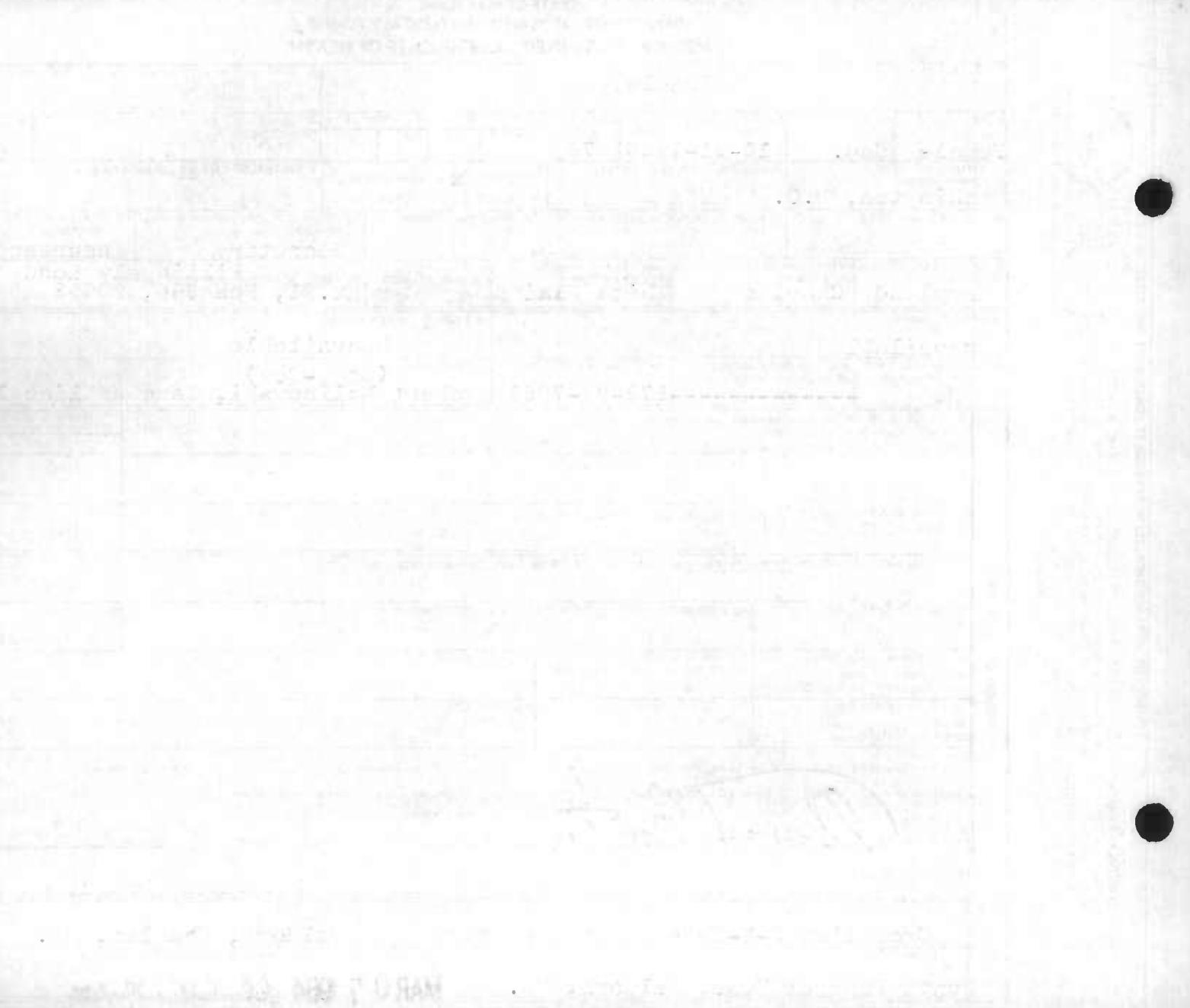
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												07/36		
1 - FOR STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Mary				Hill		Johnson		3		3	3	1984	11:23 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Female		White		Month Day Year		68		MONTHS		DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Alabama		U. S. of A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Charles County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Cobb Island		101 Southeast Crain Blvd.		Housewife		At home								
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STREET ADDRESS		13b. ZIP:										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	101 S.E. Crain Blvd. 20625		MD.									
Maryland	Charles	Cobb Island												
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
H. T. Mc Gilvray		Mattie Clay Brooks		213-84-0947		Kimbell Johnson, Cobb Island, Md. 20625								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		16c. DEATH WAS CAUSED BY:		16d. IMMEDIATE CAUSE (a)		16e. DUE TO, OR AS A CONSEQUENCE OF (b)		16f. DUE TO, OR AS A CONSEQUENCE OF (c)				
No				1629		Respiratory failure		Carcinoma lungs						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Emphysema.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21a. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1984</u> , to <u>3-3-1984</u> , that (I) <input type="checkbox"/> last saw the deceased alive on <u>2-16-1984</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE <i>G. S. Rath</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED La Plata, Maryland								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. S. Rath, M. D.		22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 03/04/84		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Clinton		23e. COUNTY P.G.		23f. STATE Md.				
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., LaPlata, Md.		ADDRESS		25. DATE REC'D BY REGISTRAR MARO 7 1984		25b. REGISTRAR'S SIGNATURE Julie Dawson-Randall								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS. AFTER DEATH, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 16. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAM. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 7737					
1. STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 3/2/84 19									2b. HOUR 12:44 M					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2c. DATE PRONOUNCED DEAD 3/2/84 19					
Mary			Bradley			B.			Malinowski			2d. DATE OF ESTI-DEATH MATED <input type="checkbox"/>					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY			
Female	Cau.	10-31-1908	75 yrs.							Charles County	La Plata	Physicians Memorial Hospital	Secretary	Insurance			
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN White Plains			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Billingsly Road Rt. #1, Box 396, 20695						
14. FATHER'S NAME FIRST Unavailable			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Unavailable		MIDDLE			LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Step-Son)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			579-09-7058			Robert Malinowski, Same as line 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Howard D. Smith</i> M.D. Dep. Chief MEDICAL EXAMINER																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORIAL Cremation 3-4-1984 Hunt Crematory															23d. LOCATION CITY OR TOWN Waldorf, Charles, Md.		
24. FUNERAL DIRECTOR NAME Hunt Crematory			ADDRESS Hunt Crematory			25a. DATE REC'D. BY REGISTRAR MAR 07 1984			25b. REGISTRAR'S SIGNATURE <i>J. K. Kinsella, Jr.</i>								
DHMH - 17 (VR A15 ME (5)) 20M 4/22																	



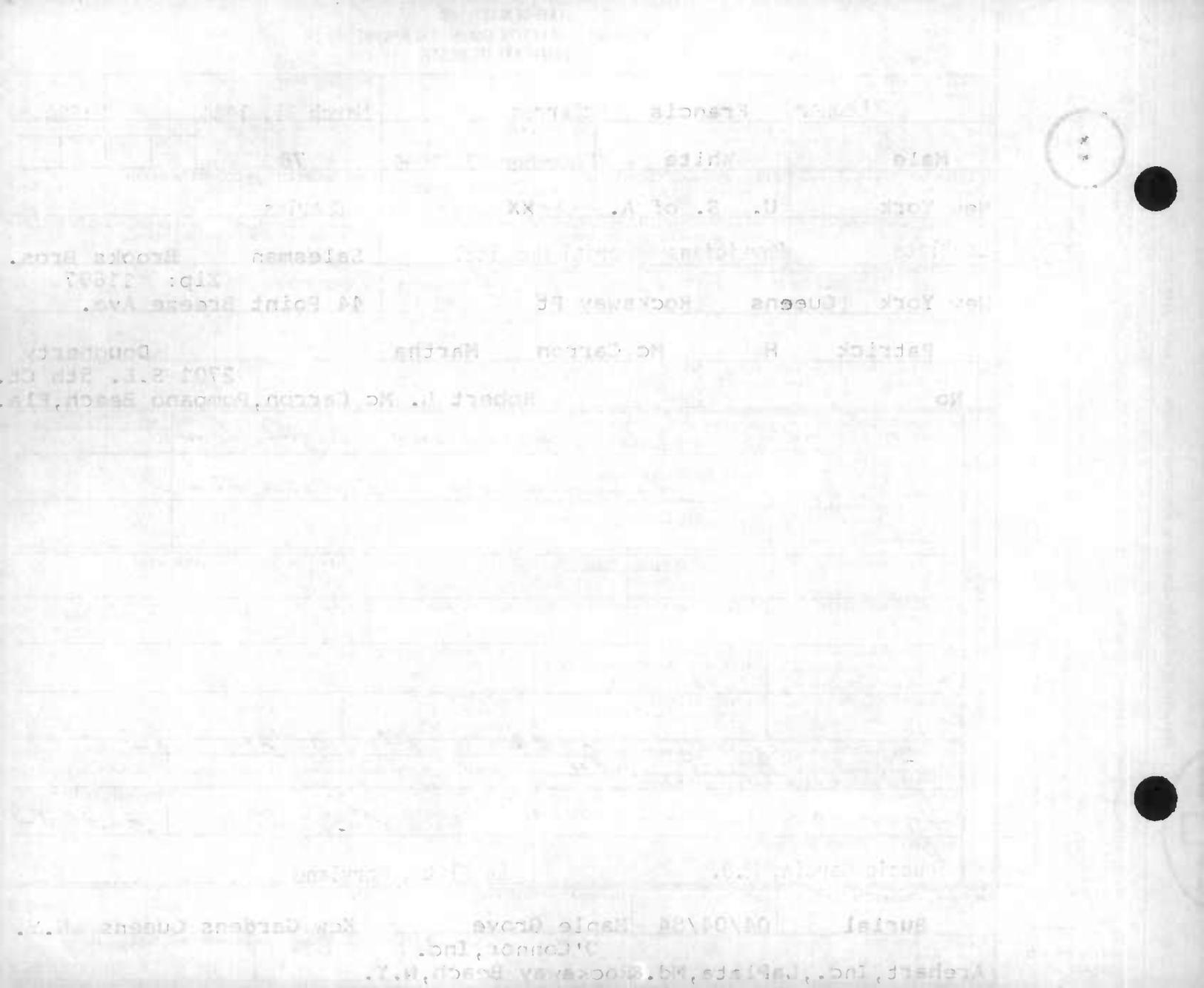
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be retained alone.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										07/38					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH							REG. NO.	2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			March 31, 1984		2:30A M			
Leonard Francis McCarron															
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
Male			White		MONTH DAY YEAR		78 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			Charles MD.					
New York			U. S. of A.		November 27, 1905										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
La Plata			Physicians Memorial Hospital							Salesman			Brooks Bros.		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			Zip: 11697		
New York			Queens		Rockaway Pt		YES <input type="checkbox"/> NO <input type="checkbox"/>			44 Point Breeze Ave.			99999		
14. FATHER'S NAME			FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME			ADDRESS			Dougherty		
Patrick H. Mc Carron							Martha			2701 S.E. 5th Ct.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Robert L. Mc Carron, Pompano Beach, Fla.					
No							1629			Adenocarcinoma Right Lung Exsanguination + dehydration					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			1629		DUE TO, OR AS A CONSEQUENCE OF (b)		Adenocarcinoma Right Lung Exsanguination + dehydration								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 3-22, 1984, to 3-31, 1984, that (I) (we) last saw the deceased alive on 3-30, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Ignacio Garcia, M.D.			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-31-84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		La Plata, Maryland										
Ignacio Garcia, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY			STATE		
Burial			04/04/84		Maple Grove			Kew Gardens, Queens, N.Y.							
24. FUNERAL DIRECTOR NAME ADDRESS Arehart, Inc., LaPlata, Md. Rockaway Beach, N.Y.															
25. DATE READ, WITNESS SIGNATURE O'Connor, Inc., LaPlata, Md. Rockaway Beach, N.Y.															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

07/39

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Joseph Everett Phillips Sr.						March 12, 1984				5:36a M		
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White	April 11 1917			66 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
North Carolina			U. S. of A						Charles			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
La Plata			Physicians Memorial Hospital			Saw Mill-Disa			So. Md. Hardwood Co.			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Charles	Marbury						Route 1 Box 283 Zip: 20658		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Everett			F	Phillips	Rosa			Belle	Phillips			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						
Yes			W.W.II			240-16-0540			Katherine R. Phillips			Same as # 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>												
4960 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ESCHIMIC CARDIOMYOPATHY w/ PULMONARY HYPERTENSION</b>												
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
<b>HEPATOMEGLY, GOUT, RESPIRATORY INFECTION</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> 19 <u>84</u> to <u>3-12</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3-12</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Aurelio Delapaz</i>		DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>3-12-84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Aurelio Delapaz, M.D.</i>		22e. ADDRESS <i>La Plata, Md. 20646</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03/14/84			23c. NAME OF CEMETERY OR CREMATORIAL St. Charles			23d. LOCATION CITY OR TOWN Glymont			COUNTY Charles	STATE Md.
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., La Plata, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 16 1984			25b. REGISTRAR'S SIGNATURE <i>Juli Davidson Rendall</i>				

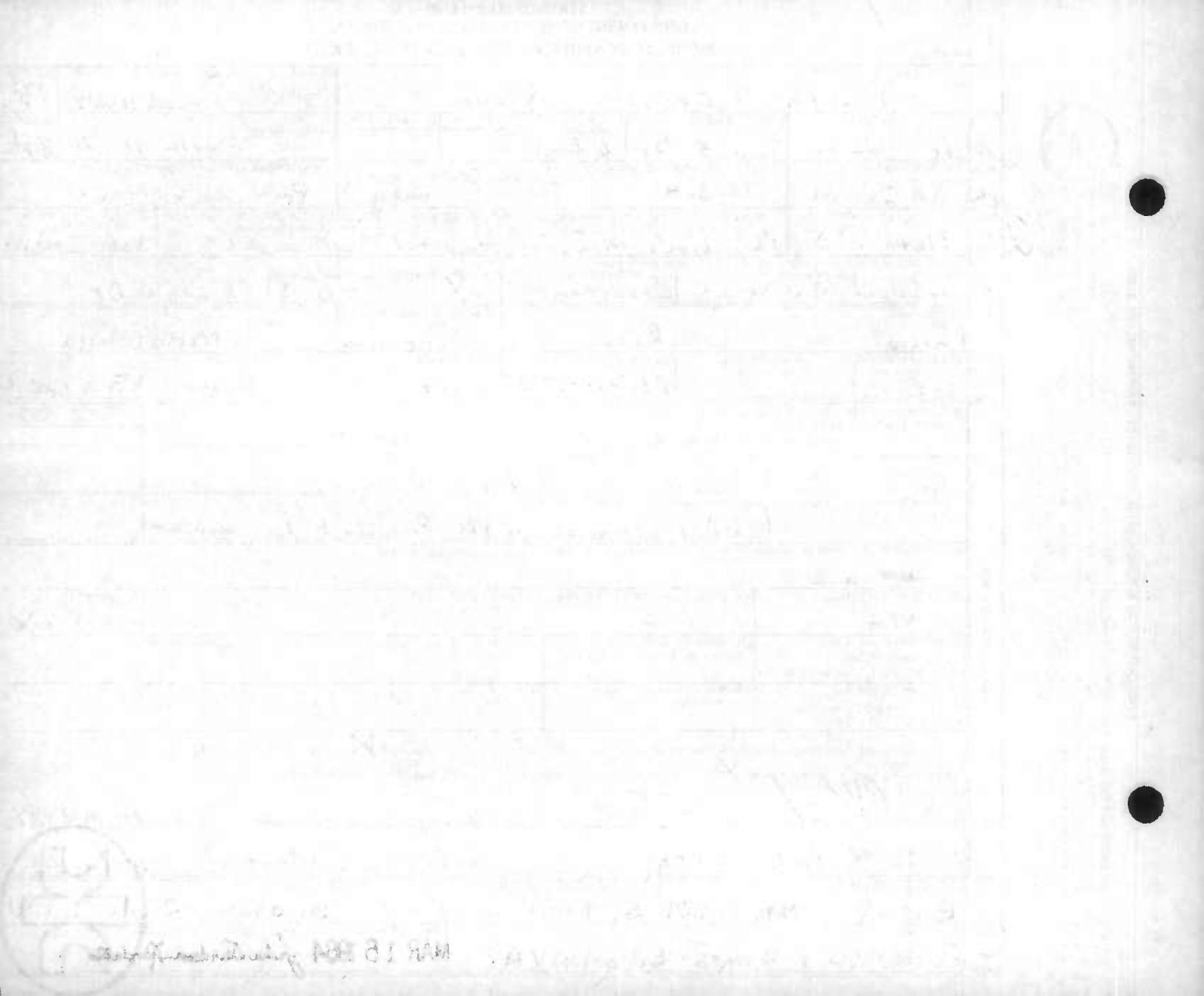
110000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 7140					
1. DECEASED NAME (TYPE OR PRINT)			FIRST Joseph			MIDDLE Frank			LAST Ricci			2a. DATE KNOWN OF EST. DEATH MATED			2b. MONTH DAY YEAR	2b. HOUR 8:30 M	
3. SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR June 8 '21			6. AGE (IN YEARS) LAST BIRTHDAY 62 yrs.			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED WIDOWED			9. NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD			10. DATE MONTH DAY YEAR March 11 1984 8:30 M		
10. CITY OR TOWN OF DEATH La Plata, MD			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tool Maker			12b. KIND OF BUSINESS OR INDUSTRY Tool Indust								
13a. STATE Rhode Island			13b. COUNTY Providence			13c. CITY OR TOWN Cranston			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 50 St. Mary's Dr					
14. FATHER'S NAME FIRST Philip			MIDDLE			LAST Ricci			15. MOTHER'S MAIDEN NAME FIRST Vincenza			MIDDLE			LAST Marandola		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 035-18-1735			17. INFORMANT Wife			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arrhythmias with Permanent Pacemaker</u>			ADDRESS Same 13A above			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). No unk																	
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Phil. Carter			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED March 12, 1984								
EXAMINER'S NAME (TYPE OR PRINT) C. Philip Carter			ADDRESS Physician's Memorial Hospital, La Plata														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 16, 1984			23c. NAME OF CEMETERY OR CREMATORIAL St. Ann's Cemetery			23d. LOCATION CITY OR TOWN Cranston, Rhode Island			23e. COUNTY Rhode Island			STATE		
24. FUNERAL DIRECTOR NAME Ines Pearson F. Horns - Arlington, VA.			ADDRESS Ines Pearson F. Horns - Arlington, VA.			25a. DATE REC'D. BY REGISTRAR MAR 16 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson - Rhode Island								
20. DMMH - 17 (VR A15 ME (5)) 20M 4/22																	



800-111-1111 (800) 800-1111

Item 11 Per 4/16/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 27141

3  
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 AND 2 SHOULD BE FILED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST Joseph	MIDDLE CAVLIN	LAST Simpson	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 3	DAY 25	YEAR 1984	2b. HOUR 11:00 P.M.		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH J	DAY 18	YEAR 61	6. AGE (IN YEARS LAST BIRTHDAY) 22	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. HOURS 0	10. MIN. 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED				
Washington, DC			USA									
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Parksway Motel					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY Construction worker	
13a. STATE MD	13b. COUNTY Ches.	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS P. O. Box 573		20601					
14. FATHER'S NAME FIRST Joseph			MIDDLE J.	LAST Simpson	15. MOTHER'S MAIDEN NAME FIRST Carol		MIDDLE A.	LAST Baynor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 223 08 8662			17. INFORMANT Joseph J. Simpson - Forest, Va. 24551						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9530 IMMEDIATE CAUSE (a) <u>Hanging - cervical fracture</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Suicide</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>H. M. Mahan</u> <u>Hoff</u> TITLE (SPECIFY) M.D. <u>Charles</u> MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) <u>H. M. Mahan - Hoff</u> ADDRESS <u>SR#1 Box 1028 LaPlata, MD 20646</u> DATE SIGNED <u>26 March 84</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-2-84	23c. NAME OF CEMETERY OR CREMATORIAL Sherwood Mem. Park	23d. LOCATION CITY OR TOWN Salem, Virginia									
24. FUNERAL DIRECTOR NAME <u>Whitten Funeral Homes</u>	ADDRESS <u>Box 489 - Lynchburg, Va.</u>	25a. DATE REC'D. BY REGISTRAR APR 02 1984	25b. REGISTRAR'S SIGNATURE <u>Juliann Sanderson</u>									
DHMH - 17 (VR A15 ME (5)) 20M 4/82												



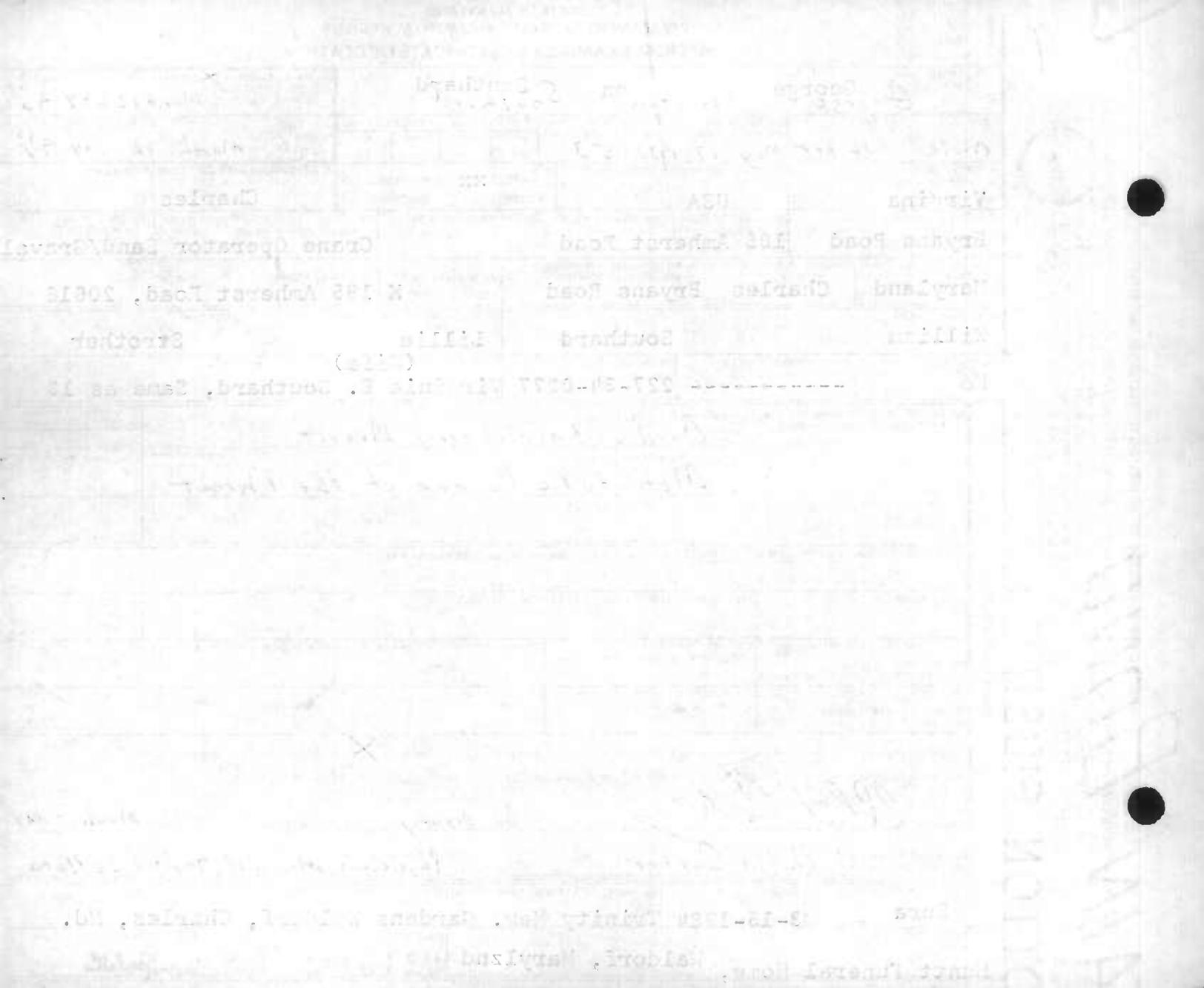
1908

1908

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 7742			
1. DECEASED NAME (TYPE OR PRINT)				LAST				2a. DATE KNOWN OF DEATH ESTI- MATED				2b. HOUR			
George Thornton S. Southard								<input checked="" type="checkbox"/> March 12, 1984				9 AM			
3. SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR					
Male	White	May 17 1930	53 yrs.	MONTHS	DAYS	March 12, 1984	1984	55	9 AM						
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		USA						Charles							
10. CITY OR TOWN OF DEATH												MD.			
Bryans Road															
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)															
185 Amherst Road															
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)															
Crane Operator Sand/Gravel															
13a. STATE Maryland												13b. COUNTY Charles	13c. CITY OR TOWN Bryans Road	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 185 Amherst Road, 20616
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
William Southard				Lillie Strother											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 227-34-0277				17. INFORMANT (Wife) Virginia E. Southard, Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 1490												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>Cardio-respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.															
(b) <i>Metastatic Cancer of the Throat</i> DUE TO, OR AS A CONSEQUENCE OF															
(c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>Philip Carter</i>															
EXAMINER'S NAME (TYPE OR PRINT) C. Philip Carter															
ADDRESS Physician's Memorial Hospital, La Plata															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 3-15-1984			23c. NAME OF CEMETERY OR CREMATORIUM Trinity Mem. Gardens			23d. LOCATION CITY OR TOWN Waldorf, Charles, Md.						
24. FUNERAL DIRECTOR NAME			ADDRESS Hunt Funeral Home, Waldorf, Maryland			25a. DATE REC'D. BY REGISTRAR MAR 15 1984			25b. REGISTRAR'S SIGNATURE <i>Linda K. Wilson-Rendell</i>						
DHMH - 17 (VR A15 ME (5)) 20M 4/82															



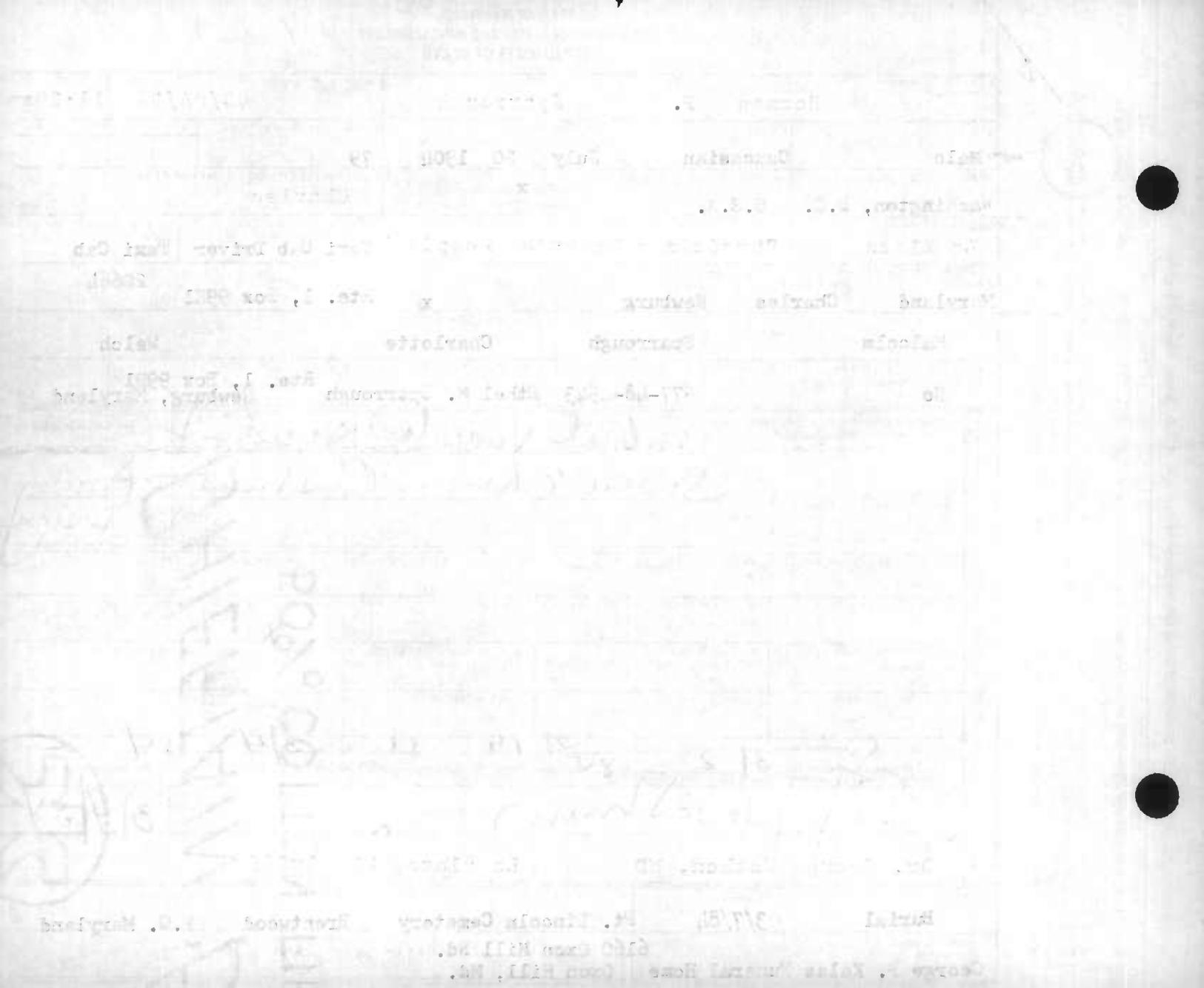
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called to the scene.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				07/43	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
	Norman	P.	Sparrough	03/04/84	11:20 am
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS	7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	
Male	Caucasian	July 20 1904	79	8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Taxi Cab Driver	
13. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Newburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rte. 1, Box 99H1	12b. KIND OF BUSINESS OR INDUSTRY Taxi Cab
14. FATHER'S NAME FIRST Malcolm	MIDDLE	LAST Sparrough	15. MOTHER'S MAIDEN NAME FIRST Charlotte	MIDDLE	LAST Welch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. 577-48-4543	17. INFORMANT Ethel M. Sparrough	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Obstruction of Artery DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Vascular Accident, Severe Chronic Obstruction of Artery Disease		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 21/16/1984 to 3/4/1984, that (I) (we) lost saw the deceased alive on 31/2/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Dr. George Wathen, MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 31/4/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George Wathen, MD	22e. ADDRESS La Plata, MD 20646				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/7/84	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery	23d. LOCATION CITY OR TOWN Brentwood	23e. COUNTY P.G. Maryland	STATE
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home	24a. DATE REC'D. BY REGISTRAR 11/4/7	24b. REGISTRAR'S SIGNATURE George P. Kalas	24c. DATE REC'D. BY REGISTRAR 11/4/7	24d. REGISTRAR'S SIGNATURE George P. Kalas	
DHMH - 16 50M 4/B2 (VRA 15, 4)					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

## MEDICAL CERTIFICATION

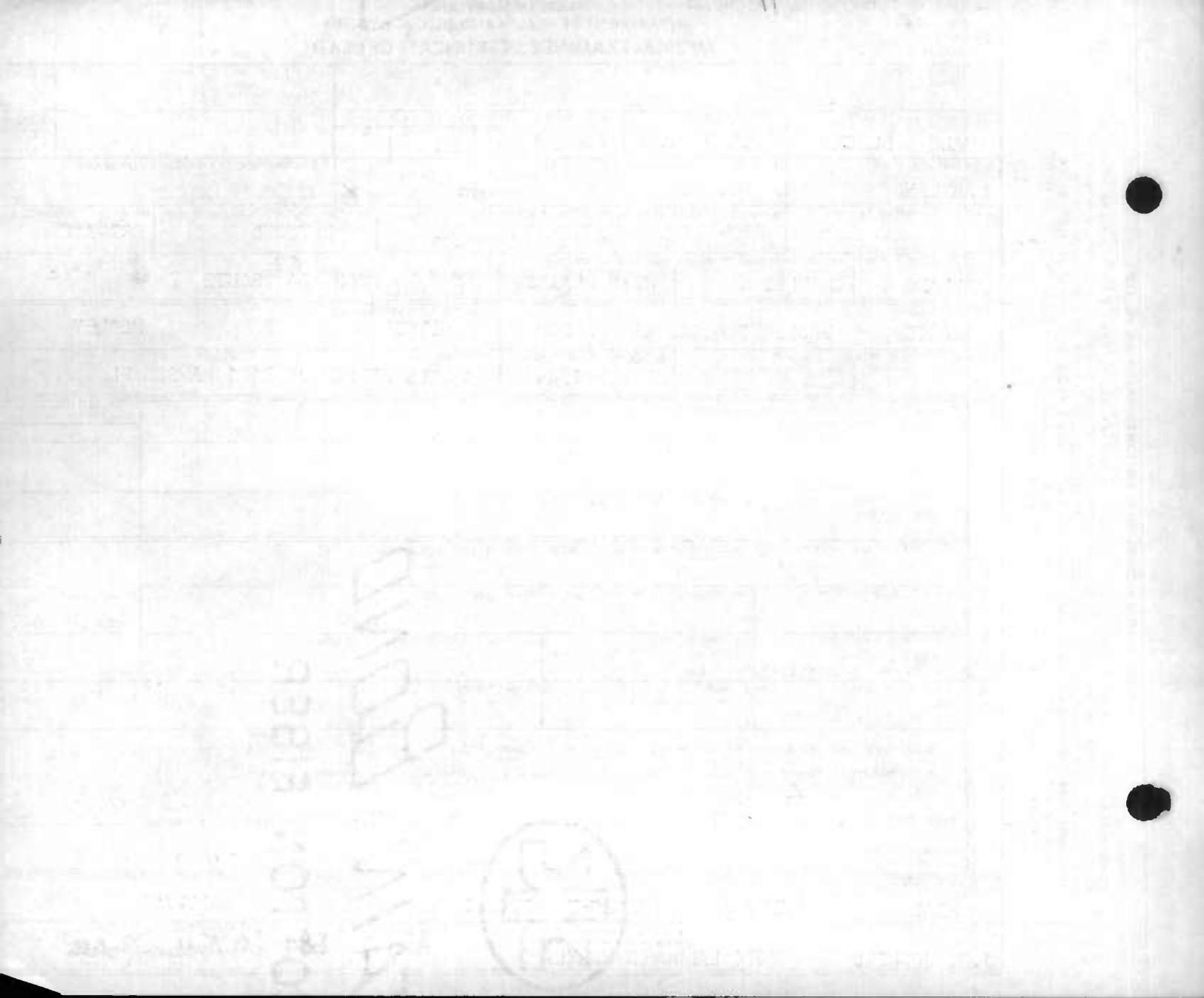
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07744						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Arthur STEWART						Thomas			MARCH 22, 1984					7:00P.M.		
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR July 23, 1923			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS			
									60		YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES		MD.					
10. CITY OR TOWN OF DEATH LAPLATA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ROOFER, G.S.A.,			12b. KIND OF BUSINESS OR INDUSTRY U.S.GOV'T							
13a. STATE maryland			13b. COUNTY CHARLES			13c. CITY OR TOWN BRYANS ROAD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1 Cheyenne Ct. 20616					
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE THOMAS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA HIMMELRIGHT													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W 2			17. INFORMANT Mrs. Mary E. Thomas, same as #13			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 4140 IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DO TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a deaths multiple																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/15/84, 19 77, to 3/22/84, 19 77, that (I) (we) last saw the deceased alive on 10/4/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																
22b. SIGNATURE William Kent Furst										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-23-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Kent Furst			22e. ADDRESS 11701 Livingston Road, Ft. Wash, Md. 20744													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE March 27, 84			23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND VETERAN CEM.			23d. LOCATION CITY OR TOWN CHELTENHAM, P.G., MARYLAND		COUNTY	STATE				
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, 6633 OLD ALEXAND- er Ferry Rd, Clinton, Maryland									25a. DATE REC'D. BY REGISTRAR MAR 29 1984		25b. REGISTRAR'S SIGNATURE Julie Sanderson-Randall					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HUMAN AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

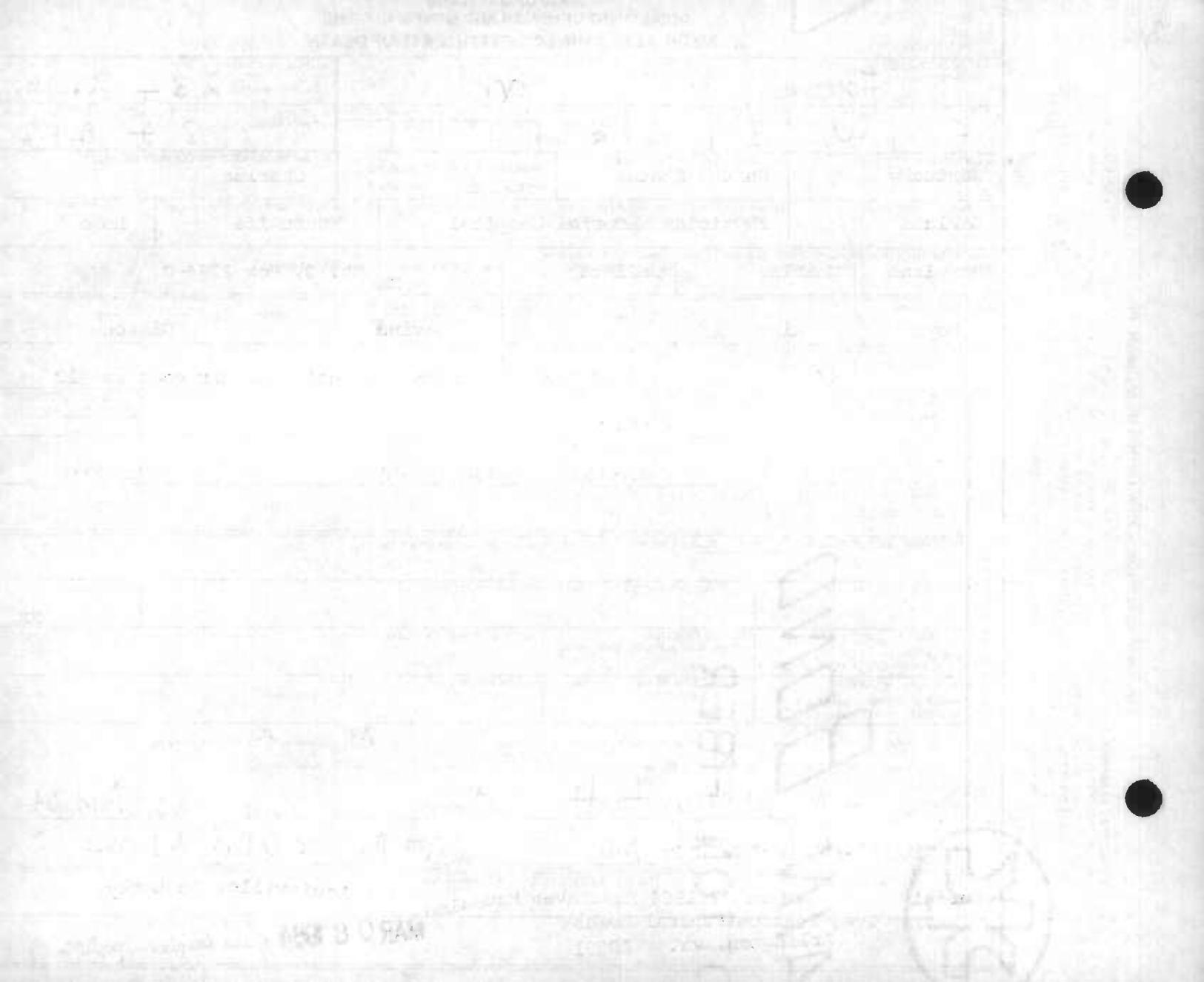
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 7 1 4 5							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED		2b. MONTH DAY YEAR	2b. HOUR				
Garnell			Joseph			Wilson						<input checked="" type="checkbox"/>		3/20/84					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		9. HOUR	
MALE		BLACK		APRIL 30 1905			78							3/20/84		P M		9:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH										
MARYLAND			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED			Charles County										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR 100% OF WORKING LIFE)			12b. KIND OF BUSINESS (OR INDUSTRY)										
LaPlata			Physicians's Memorial Hospital			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12c. STREET ADDRESS BOX 64 ROUTE 2 20695			RETIRED			PRIVATE				
13a. STATE MARYLAND			13b. COUNTY CHARLES		13c. CITY OR TOWN WHITE PLAINS		15. MOTHER'S MAIDEN NAME AGUSTUS			16. FATHER'S NAME FIRST MIDDLE LAST GEORGE WASHINGTON CARVER WILSON			17. INFORMANT GARNELL WILSON JR 3101 MANSON PL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578-09-1744			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion													
ACTUAL SIGNATURE			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 3/21/84													
EXAMINER'S NAME (TYPE OR PRINT)			Gregory R. Kauffman, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3/27/84			23c. NAME OF CEMETERY OR CREMATORIAL HARMONY NATIONAL PARK			23d. LOCATION CITY OR TOWN LANDOVER MARYLAND COUNTY STATE										
24. FUNERAL DIRECTOR NAME J.B. JENKINS			ADDRESS LANDOVER ROAD 7474 LANDOVER MARYLAND			25a. DATE REC'D. BY REGISTRAR APR 4 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. REMAINING PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												7146									
												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST Florence			MIDDLE K.			LAST York			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 34	DAY 19	YEAR 84	2b. HOUR 9:20 AM					
3. SEX <input checked="" type="checkbox"/> F		4. RACE <input checked="" type="checkbox"/> W		5. DATE OF BIRTH MONTH 12			DAY 31			YEAR 1986			6. AGE (IN YEARS LAST BIRTHDAY) 87 yrs.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	MIN 0	2c. DATE PRONOUNCED DEAD	MONTH 34	DAY 19	YEAR 84	2d. HOUR 8:20 AM
7a. BIRTHPLACE (STATE OR Kentucky)			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Charles												
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Physician Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home												
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland			13b. COUNTRY Charles			13c. CITY OR TOWN LaPlata			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 2, Box 2364-C			20646						
14. FATHER'S NAME FIRST Boyd			MIDDLE King			LAST			15. MOTHER'S MAIDEN NAME FIRST Lavina			MIDDLE Gibson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 405-12-5680			16c. INFORMANT Sandra Karlucci Daughter same as #13			ADDRESS												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Fears												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>H. M. Nathan-Haft</u> TITLE (SPECIFY) <u>M.D.</u> Charles Co. MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) <u>H. M. Nathan-Haft, MD</u> ADDRESS <u>58th Box 1020, LaPlata, Md 20646</u> DATE SIGNED <u>5 March 84</u>																					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE March 7, 1984			23c. NAME OF CEMETERY OR CREMATORIAL RestHaven Mausaleu			23d. LOCATION Louisville, Kentucky												
24. FUNERAL DIRECTOR NAME Tives-Pearson Funeral Homes Arlington, Va.			25. DATE RECEIVED BY REGISTRAR MAR 08 1984			26. REGISTRAR'S SIGNATURE Julie Davidson-Randall															
DHMH - 17 (VR A15 ME (5)) 20M 4/82																					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 07747

1- STATE  
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
Albert					Young	<input checked="" type="checkbox"/>	3	26	84	M		
1. SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR.	8 IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Male	Negro	1-18-18	66 YRS.	MONTHS	DAYS	HOURS	MIN.	3	26	84	7:11 M	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED	NEVER MARRIED	<input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.			WIDOWED	DIVORCED	<input type="checkbox"/>	Charles County, MD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
La Plata			Physicians Memorial Hospital			Farmer			Private			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland	Charles	Rison	YES	<input type="checkbox"/>	NO	<input checked="" type="checkbox"/>	General Delivery 20681					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS
Ignatius Young			Unknown			Yes 8/42-12/45			214-30-2279			Ida Watts 22 Danbury St., S.E. Wash. D.C.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		23a. EXAMINER'S NAME (TYPE OR PRINT)			23b. TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER				DATE SIGNED 3/27/84
Ann M. Dixon, M.D.		23c. ADDRESS 111 Penn St. Balto., MD.										
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE 3-29-1984			23c. NAME OF CEMETERY OR CREMATORIUM Md. Veterans Cemetery			23d. LOCATION CITY OR TOWN Cheltenham, P.G.			COUNTY	STATE
Burial												
24 FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REGD. BY REGISTRAR MAR 30 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				
Thornton's Funeral Home		Pomonkey, Maryland										

